COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

OFFICE OF THE DEPUTY DIRECTOR

December 23, 2008

To: All Specialized Foster Care Staff

From: Olivia Celis, Deputy Director
Child Youth and Family Services Program

Subject: **SFC GUIDELINES MANUAL LETTER NUMBER 1**

Attached is a copy of Specialized Foster Care (SFC) Guidelines Manual Letter Number 1. This release is the first in a series of manual letters that will be issued to SFC staff providing guidelines to be utilized when implementing the various programs designed to meet the objectives contained in the Katie A. Settlement Agreement.

This release provides guidelines to be followed by SFC staff when participating in DCFS Resources Utilization Management Process (RMP) meetings. These meetings concern DCFS children in need of or at risk of placement into RCL 6 through 14 facilities, or in need of replacement from one RCL 6 through 14 facility to another.

This letter provides a brief description of the Katie A. settlement agreement, the RMP process, the role of key DCFS staff at RMP meetings, and a detailed description of the key roles and responsibilities of SFC co-located clinical staff when participating in RMP meetings.

Attached to the letter are the five primary forms used when conducting RMP meetings:

- The DCFS 174, Family Centered Conference Referral Form,
- The Safety/Action Plan
- The Child and Adolescent Needs and Strengths – Child Welfare version (CANS-CW)
- The RMP Case Closing Summary Report, and
- The DCFS 179-MH, Consent for Treatment

Any questions regarding this manual letter may be directed to Greg Lecklitner, District Chief of Child Welfare Division, at (213) 738-4620 or GLecklitner@dmh.lacounty.gov

OC:GL:ef

DEPARTMENT OF MENTAL HEALTH
CHILD WELFARE DIVISION
SPECIALIZED FOSTER CARE GUIDELINES MANUAL

MANUAL LETTER NUMBER: 1

SUBJECT: DMH PARTICIPATION IN DCFS RMP MEETINGS

EFFECTIVE DATE: 12-01-08 **APPROVED: ☑ DMH ☑ DCFS**

I. PURPOSE

This release issues procedural guidelines for use by co-located DMH staff to assist them in participating with DCFS staff in their use of Resources Utilization Management Process (RMP) Meetings to provide services, including mental health services, to children in need of, or placed within, RCL 6 through 14 placement facilities.

II. BACKGROUND

In 2002, a class action lawsuit (Katie A.) was filed against the State of California and Los Angeles County, alleging that children in contact with the Los Angeles County's foster care system were not receiving the mental health services to which they were entitled. In July 2003, the County entered into a settlement agreement resolving the County-portion of the lawsuit. Under the terms of the agreement, the County was obligated to make a number of systemic improvements to better serve children with mental health needs. Specifically, the County was ordered to ensure that class members:

A. Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs,

B. Receive care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability,

C. Be afforded stability in their placements, whenever possible, and

D. Receive care and services consistent with good child welfare and mental health practice and the requirements of law.

DCFS designed the RMP as one means of improving the service delivery system to respond to the lawsuit and help ensure that the objectives listed above are met.

III. DESCRIPTION OF THE DCFS RMP

A. RMP meetings are a variation of TDM meetings in that they both share the following major characteristics:

1. They both facilitate the planning and decision making process by pulling together at one meeting all of the key participants needed to arrive at a consensus on what needs to be done to best meet the needs of the child. These include family members, extended family members, service providers, parent advocates, other members from the community, as appropriate, and staff from both DCFS and DMH.

2. They both make use of the DCFS 174, Family Centered Conference Referral Form (Attachment A). This form, formerly known as the Unified Referral Form, was created to simplify the referral process for a CSW. It replaces all forms previously used when requesting a TDM and combines the referral form for TDM and the referral forms for Wraparound, System of Care (SOC), other basic and intensive mental health programs, child care, and mentoring and the above mentioned DMH programs.

3. They both are intended to produce a Safety/Action Plan (Attachment B), which spells out the intervention steps to be taken to help ensure the ongoing safety of the child.

4. Both meetings are conducted by a DCFS TDM Facilitator, who has broad knowledge of DCFS policies and procedures, and of available community resources.

   Key responsibilities of TDM Facilitators include maintaining neutrality with respect to all meeting participants and working to develop a consensus among the participants on the best course of action to take with regard to the child. They do this by finding common ground amid diverse interests and opinions, focusing on family strengths, utilizing negotiation and active listening skills, and taking the lead in developing the Safety/Action Plan for the child at the conclusion of the meeting.

B. RMP meetings differ from usual TDM meetings, however, in the following ways:

1. The target client population of RMP meetings is children in need or at risk of placement into RCL 6 through 14 facilities, or in need of replacement from one RCL 6 through 14 facility to another.

2. In addition to the staff who typically attend TDM meetings, RMP meetings are attended by DCFS RUM staff and DMH clinical staff, who participate in the meeting to assist the team in making the best decisions possible regarding the child's need for mental health and other services.

3. Participating DCFS and DMH staff are all authorized to make final decisions regarding the child, with input from the family and those supporting the family, thus streamlining the process by averting the need for additional follow up meetings.

4. In lieu of the Structured Decision Making (SDM) tool used by the DCFS CSW at TDM meetings, RMP meetings utilize the Child and Adolescent Needs and Strengths – Child Welfare version (CANS-CW) to assess the child's needs and strengths and needs (Attachment C). This form is the universal assessment tool utilized by RUM staff to identify the strengths and needs of children in their school, home, and community environments. It is used to evaluate the child's functioning in terms of school performance, conduct and behavior, social relationships, moods and emotions, substance use, thinking, and aggressive and self-harmful behaviors.

   The CANS-CW also assesses the child's primary and substitute caregivers' ability to provide a safe and emotionally nurturing environment, including their ability and willingness to participate in recommended services. The CANS-CW helps inform decisions regarding the level of intensity of services and/or the level of placement needed by the child.

   DCFS RUM staff and DMH clinical staff are responsible for completing applicable sections of the CANS-CW prior to the RMP meeting and for discussing the results of the CANS-CW at the meeting. DCFS staff will complete Sections A and B and Sections D through I of the form, while DMH staff is responsible for completing Section C, Mental Health Needs.

   If, due to time constraints, it is not possible to complete the CANS-CW prior to the TDM meeting, the form will be completed as soon as possible following the meeting. Typical situations include cases referred to DCFS via their Emergency Response Units that require Initial TDM meetings due to safety concerns for the child.

5. Both DCFS and DMH staff are also expected to bring to the meeting a list of potential community resources that may be needed by the child and family. DCFS RUM staff are responsible for bringing a current list of all services and available potential placements located in the youth's community, while DMH staff are responsible for bringing a list of current mental health resources available in that community.

   RMP meetings will utilize resources including DMH Intensive In-Home Mental Health Services programs including, Multidimensional Treatment Foster Care (MTFC), Multi-systemic Treatment (MST), and the Comprehensive Children's Services Program (CCSP), and DCFS's intensive services, including Wraparound, Intensive Treatment Foster Care (ITFC) and RCL 6 and above residential care.

IV. RMP SCHEDULING IN EMERGENCY SITUATIONS

DCFS will attempt to schedule an RMP within three (3) business days in the following situations:

A. When the child was moved after hours, or on an emergency basis. In such situations, the CSW will notify the TDM scheduler of the need to schedule an RMP within three business days following the date of placement.

B. When a 7-day notice has been received from a foster home placement. In such situations, DCFS will attempt to schedule an RMP within three business days following receipt of the notice.

V. DCFS STAFF RESPONSIBILITIES

The roles and responsibilities of DCFS staff with regard to RMP meetings can be found in DCFS Procedural Guide 0070-548.03, Point of Engagement: Team Decision-Making, issued 12/21/05, and in DCFS Procedural Guide 0100-525.40, Team Decision Making: The Resources Management Process (RMP/TDM), issued November, 2008.

The above procedures indicate that the DCFS case carrying CSW is the DCFS staff member primarily responsible for making arrangements for the TDM meeting. He/she does this in consultation with the SCSW and in the process interfaces with the family, the DCFS TDM Scheduler, the TDM Facilitator, DCFS RUM staff and co-located DMH staff. He/she also provides access to the case so that DCFS RUM staff and DMH clinical staff can complete the CANS-CW.

DCFS RUM staff, however, are responsible for taking the lead in completing the CANS-CW and for contacting DMH clinical staff for purposes of collaboratively completing the CANS-CW prior to the TDM meeting.

VI. DMH CO-LOCATED CLINICAL STAFF RESPONSIBILITIES/PROCEDURES

A. DMH Clinical Supervisor

1. Receives and reviews the DCFS 174, Family Centered Conference Referral form, submitted by the DCFS case carrying CSW, and forwards the referral to the appropriate DMH clinician.

2. Provides consultation to the DMH clinician, as needed, both prior to and following the TDM meeting.

3. Reviews, discusses, approves and signs the Case Closing Summary Report (Attachment D) submitted by the DMH clinician within 60 days following the RMP meeting, indicating the extent to which the Safety/Action Plan was implemented successfully and that the RUM case may be closed.

B. DMH Clinician

1. Receives and reviews the referral assigned by the supervisor.

2. Inquires into the DMH IS data base to find out if there is any previous information on the case within the system, and prints any available hard copies of such data for inclusion in the case folder.

3. Contacts any previous or current mental health (MH) service providers to obtain any case information they may have.

4. Contacts the referring CSW to determine if he/she has any other additional case information that might be helpful in understanding the scope of the problem and possible intervention strategies.

5. Asks the referring CSW whether or not the case contains a DCFS 179-MH, Consent for Mental Health Treatment form (Attachment E), signed either by the parent or the child, or whether or not such consent has been obtained through the court. If so, obtains a copy from the CSW; if not, arranges with the CSW to have the parent or child sign the form while attending the TDM meeting. If that does not appear feasible, asks the CSW to submit a consent request to the court as soon as possible.

6. If sufficient information is not available to complete Section C of the CANS-CW, Mental Health Needs, arranges to make a face-to-face contact with the child and uses the information obtained in the face-to-face interview to complete that section of the CANS-CW.

7. If not already contacted by the DCFS RUM staff person working on the case, contacts that worker to make arrangements to complete the CANS-CW. Ideally, this should be done together to facilitate mutual understanding of the case and the sharing of thoughts and case information.

8. Utilizing all available case information, formulates a preliminary service intervention plan. Depending upon the resources contemplated, contacts the appropriate DMH staff persons administering those programs to determine if the child meets eligibility requirements. Based upon those discussions, prepares a list of potential mental health resources to take to the RMP meeting.

9. Consults the Clinical Supervisor to discuss and obtain feedback on the preliminary plan and makes any necessary adjustments to the plan based upon that discussion.

10. Contacts the appropriate DCFS RUM staff involved in the case to discuss the preliminary plan agreed upon in consultation with the Clinical Supervisor.

11. Participates in and provides clinical expertise at the RMP meeting, and assists the TDM Facilitator in developing the Safety/Action Plan.

12. Following the TDM meeting, provides follow up support, as needed, to the case carrying CSW by means of ongoing consultation, assistance with problem solving and/or MH case management services.

13. Within two months following the TDM meeting, assists the assigned RUM staff person in completing a Case Closing Summary Report to indicate the extent to which the Safety/Action Plan was successfully implemented and that the RUM case may be closed. Signs and submits the report to the Clinical Supervisor for his/her review and approval.

Attachment A
Family Centered Conference Referral Form

Family Centered Conference Referral Form

CSW Instructions:

1. *Complete Page 1 only*
2. *Submit to SCSW for Approval*
3. *Submit to Scheduler*

Date of Referral	Case Name	Referral/State No.	Court # *(if applicable)*
CSW	CSW Phone	Office	
SCSW	SCSW Phone	SDM Attached ☐ Yes ☐ N/A	CIMH/MHST Included ☐ Yes ☐ No
Primary Language of Conference	Service Component ☐ ER ☐ Voluntary ☐ Court	Domestic Violence ☐ Yes ☐ No	Security Needed ☐ Yes ☐ No
Type of Conference ☐ FGDM ☐ PPC ☐ RMP ☐ TDM ☐ Transitional Conference			

Has the family had a Conference before? ☐ Yes ☐ No If yes, what type and when?

Primary Purpose/Concerns for the conference:

Child Information ***(please indicate if attending)***

Child's Name	DOB/Age	Current Placement	Is Child Detained?	Detention Date	MCAL	MCAL Provider
1	/		☐ Yes ☐ No		☐ Yes ☐ No	
2	/		☐ Yes ☐ No		☐ Yes ☐ No	
3	/		☐ Yes ☐ No		☐ Yes ☐ No	
4	/		☐ Yes ☐ No		☐ Yes ☐ No	
5	/		☐ Yes ☐ No		☐ Yes ☐ No	

Caregiver Information

Name	Address	Phone Number	Relationship	Willing Participant?
				☐ Yes ☐ No
				☐ Yes ☐ No

School Name	Location	Phone Number

Family/ Extended Family, Community Support, Service Providers to be invited ***(include providers already involved):***

Name	Address	Phone Number	Relationship	Willing Participant?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Service Providers, DCFS Staff/Resources to be invited

☐ ISW CSW/SCSW	☐ PHN	☐ RUM	☐ Adoptions/P3	☐ Wrap/SOC
☐ Voluntary Services	☐ DMH	☐ YDS	☐ Educ. Liaison	☐ Service Provider/Caregiver
☐ Parenting	☐ Counseling	☐ Domestic Violence	☐ DPSS	
☐ Drug/Alcohol	☐ Probation	☐ Fam. Pres.	☐ Other	

SCSW'S Signature *(required)* _____ Date: _____

Page 2 and 3 must be completed by Facilitator and returned to the CSW within 24 hours after conference

Family Centered Conference Referral Form

Conference Location	Conference Facilitator	Conference Date	Start Time	End Time

Type of Conference:

- ☐ **A:** Imminent risk of Placement
- ☐ **B:** Emergency Placement
- ☐ **C:** Placement Move
- ☐ **D:** Exit from Placernent
- ☐ **E:** DCFS Case Plan/Update
- ☐ **F:** FGDM
- ☐ **G:** Transitional Conf.
- ☐ **H:** PPC
- ☐ **I:** RMP

Reason Conference Cancelled:

- ☐ CSW's request
- ☐ Families' request
- ☐ Reason for conference no longer valid
- ☐ Child/family referred to more appropriate services
- ☐ Child not available

FGDM only: ☐ Yes ☐ No

Concerns of Family/Child

- ☐ Domestic Violence
- ☐ Educational/Tutoring
- ☐ Youth Transitional Services
- ☐ Health Services
- ☐ Housing
- ☐ Mental Health
- ☐ Permanency- (Adopt/LG)
- ☐ Sexual Abuse
- ☐ Substance Abuse
- ☐ Probation
- ☐ Other *(specify):*

SDM Risk Level

- ☐ Low
- ☐ Moderate
- ☐ High
- ☐ Very High/Intensive
- ☐ SDM not available

Did anyone leave meeting? ☐ *Yes* ☐ *No*
If yes, why?

Check all that attended and, if there is more than one person in a category, write in number of people who attended:

Caregivers:

		M	F
☐ Birth Parent(s)	#		
☐ Adoptive Parent(s)	#		
☐ Other Relative Caregiver(s)	#		
☐ Non-Related Extended Family Member(s)	#		
☐ County Foster Parent(s)	#		
☐ FFA Foster Parent(s)	#		
☐ Caregiver Partner(s)	#		
☐ Guardian(s)	#		

*** Is the caregiver a victim of DV or SA?** ☐ Yes ☐ No
*** Is the caregiver a DV or SA offender?** ☐ Yes ☐ No

Children/Youth:

- ☐ Children/Youth #
- ☐ Child Victim #
- ☐ Child Offender #

Family Members and other interested individual

- ☐ Maternal Relative(s) #
- ☐ Paternal Relative(s) #
- ☐ Friend(s) #
- ☐ Interested Individual(s) #

Neighborhood/Community Representatives:

- ☐ Community Representative(s) #
- ☐ School Staff #

Facilitators Present #

Other:

- ☐ Guardian Ad litem #
- ☐ Attorney #
- ☐ CASA Advocate #
- ☐ Other *(specify):* _____ #

DCFS Staff:

- ☐ Emergency Response CSW #
- ☐ Generic (FM/FR/PP) CSW #
- ☐ ISW #
- ☐ DI #
- ☐ Worker on Companion Case #
- ☐ YDS/Aftercare Workers #
- ☐ Adoption CSW #
- ☐ SCSW #
- ☐ Family Preservation Staff #
- ☐ Wraparound Staff #
- ☐ Other Strength Based Program Staff #
- ☐ Public Health Nurse #
- ☐ RUM Liaison #
- ☐ Educational Consultant #
- ☐ P3 CSW #
- ☐ Other *(specify):* _____ #

Service Providers:

- ☐ Alcohol / Drug Staff #
- ☐ DPSS Staff #
- ☐ Domestic Violence Staff #
- ☐ Educational/Tutoring Staff #
- ☐ FFA Social Worker #
- ☐ Medical Staff #
- ☐ Mental Health Staff #
- ☐ Group Home Staff #
- ☐ Regional Center Staff #
- ☐ Sexual Abuse Staff #
- ☐ Probation #
- ☐ Family Preservations #
- ☐ Wraparound #
- ☐ Other *(specify):* _____ #

Page 2 and 3 must be completed by Facilitator and returned to the CSW within 24 hours after conference

Family Centered Conference Referral Form

(Please use a separate copy of this page for each identified child)

Conference Decision Regarding Child _____

(Name)

A: Imminent risk of placement
- ☐ Child stays home/ voluntary contract
- ☐ Child stays home/court involvement
- ☐ Voluntary placement
- ☐ Court placement
- ☐ Referral closed/ no DCFS involvement

B: Emergency Placement
- ☐ Return child home/ voluntary contract (VFM)
- ☐ Return child home/ court involvement (FM)
- ☐ Continue voluntary placement
- ☐ Continue court placement
- ☐ Child returns home/ no DCFS involvement

C: Placement Move
- ☐ Change to less restrictive placement
- ☐ Maintain child in present placement
- ☐ Change to same level placement
- ☐ Change to more restrictive placement

D: Exit from Placement
- ☐ Reunification
- ☐ Adoption
- ☐ Guardianship
- ☐ Youth Transition
- ☐ Terminate jurisdiction

E: DCFS Case Plan/ Update
- ☐ DCFS Case Plan developed
- ☐ DCFS Case Plan not developed
- ☐ Case Closed (Voluntary)
- ☐ Case Closed (Court)

F: Permanency Placement Plan
- ☐ Reunification
- ☐ Adoption
- ☐ Guardianship
- ☐ Youth Transition

G: Youth Transition Plan
- ☐ Education ☐ Housing
- ☐ Work ☐ Mentor

Reason for ARA Review/Consultation.
- ☐ Unable to Reach Consensus
- ☐ Facilitator's Request
- ☐ 0-59 Months Remaining or Returning Home
- ☐ 0-59 Months More Restrictive Placement
- ☐ 0-59 Months Termination of Jurisdiction

When conference decision is to change child's placement, please check new placement recommendation.
- ☐ Small Family Home
- ☐ Foster Family Home
- ☐ FFA
- ☐ D-Rate Foster Care
- ☐ Court Specified
- ☐ Medical Facility
- ☐ Tribe Specified Home
- ☐ MTFC/ITFC
- ☐ Relative Home
- ☐ Non Relative Family Member
- ☐ Guardian Home
- ☐ THPP
- ☐ Group Home *(specify RCL level):* _____

DCFS Specialized Services Recommended for the CHILD/FAMILY:
- ☐ Family Pres.
- ☐ DPSS Linkages
- ☐ DHS/HUB
- ☐ Wraparound
- ☐ Kinship
- ☐ Child Care
- ☐ Mentoring
- ☐ ITFC
- ☐ Res. Based Services
- ☐ Youth Development Services
- ☐ Education Consultant
- ☐ Other *(specify):* _____

Mental Health/ Counseling Services Recommended for the CHILD/FAMILY:

Community based agency (DMH and non DMH)
- ☐ Dom. Violence Treatment
- ☐ Sexual Abuse Treatment
- ☐ Substance Abuse Treatment
- ☐ DMH
- ☐ MAT Assessment
- ☐ AB 3632 referral
- ☐ D-rate unit
- ☐ TBS
- ☐ CAPIT (1733/ Child Abuse Prevention)
- ☐ Other *(specify):* _____

☐ DMH Mental Health Co-located staff *(will refer and consult on all referrals for mental health services)*

Intensive Mental Health Services
- ☐ Multi Systemic Therapy
- ☐ WRAP/SOC
- ☐ Comp Child Services Program (CCSP)
- ☐ Intensive Home-Based Services (IHBS)
- ☐ MTFC
- ☐ FSP

Other Community Services for the CHILD/FAMILY:

	Family	Child		Family	Child
Counseling/Mental Health Services	☐	☐	Educational Services	☐	☐
Substance Abuse Treatment	☐	☐	Medical Services	☐	☐
Housing Services	☐	☐	Regional Center Services	☐	☐
Domestic Violence	☐	☐	Sexual Abuse Treatment	☐	☐
Parenting Classes	☐	☐	Other *(specify):* _____	☐	☐

CSW Next Steps:

1. *If child(ren)/family are referred for services, attach the Safety/Action Plan to this form and provide it and any additional information to the service provider and caregiver.*
2. *Attach minute order for mental health treatment, if available.*
3. *Fill out **only** the appropriate attached section(s) for the specific service recommended to complete your referral.*
4. *A copy of this form and the attached Safety/Action Plan are to be filed in the case file.*
5. *Schedule a first visit (icebreaker), if the child is removed from the home.*
6. *Schedule a 30-day Permanency Planning Conference, if needed.*

Attachment B
Safety/Action Plan

PATRICIA S. PLOEHN, LCSW
Director

County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Safety Action Plan

Case Name: _____ **Child(ren) Name (s):** _____

Facilitator: _____ **Date:** _____

All responsible parties must agree and sign. If the Safety Action Plan is being used when the child is to remain in the parents' home or when the child is being voluntarily placed (VFR), the parent or parents must agree to the Plan. The Parties agree to the terms of this plan until DCFS Case Plan is completed and signed.

Activity	Person(s) Responsible	Time Frame
1.		
2.		
3.		
4.		

Case Name: _____ Child(ren) Name (s): _____

Facilitator: _____ Date: _____

Activity	Person(s) Responsible	Time Frame
5.		
6.		
7.		
8.		
9.		
10.		

Case Name: _____ Child(ren) Name (s): _____

Facilitator: _____ Date: _____

Agreed to Safety Plan and received copy of Team Conference

Mother	**Signature**
Father 1	**Signature**
Father 2	**Signature**

Agreed to Safety Plan

Name/Relationship	**Signature**
Name/Relationship	**Signature**
Name/Relationship	**Signature**
Name/Relationship	**Signature**
Name/Relationship	**Signature**
Name/Relationship	**Signature**
Name/Relationship	**Signature**
Name/Relationship	**Signature**

Attachment C
has been sent as a separate document

Attachment C
Child Adolescent Needs and Strengths – Child Welfare (CANS-CW)

Attachment D
Case Closing Summary Report

RESOURCE MANAGEMENT PROCESS (RMP)
EXIT/SUMMARY REPORT

Date:	
Name of Youth:	**Date of Birth:**
Current Placement/Level:	
RMP (TDM) Date:	
DMH Liaison:	
RUM Liaison:	
CANS completion Date:	**DMH Participation: Y: ☐ N: ☐**
CANS Recommendation:	
RMP Recommendation:	

TDM/RMP Action Plan

Activity	Responsible Party	Completed
		Y: ☐ N:☐
		Y: ☐ N:☐
		Y: ☐ N:☐
		Y: ☐ N:☐
		Y: ☐ N:☐
		Y: ☐ N:☐

Summary/Disposition:

Signatures and Dates:

CSW:	**SCSW:**
RUM Liaison:	**RUM SCSW:**
DMH Liaison:	

Attachment E
Consent for Mental Health Treatment

PARENTAL CONSENT FOR CHILD'S MENTAL HEALTH ASSESSMENT AND FOR CHILD'S PARTICIPATION IN MENTAL HEALTH TREATMENT

Name of Child: Date of Birth:

In 2002, a lawsuit was filed against the State of California and Los Angeles County on behalf of children in contact with the County's foster care system stating that they were not receiving mental health and other services that they were supposed to receive. In July 2003, the County entered into a settlement agreement, and it agreed to ensure that the needs of children in or at risk of foster care were identified and to provide them with the mental health services that they needed.

Because we want to ensure that your child's mental health needs are identified and that he or she receives any needed mental health services, we are asking you to agree that your child may be given a mental health assessment and that he or she may receive any recommended mental health services from a mental health professional.

YOU DO NOT HAVE TO AGREE TO THIS. If you do not agree, we will not hold this against you. However, we want you to know that if you do not agree, the law allows us in some instances to go to court and ask the court for permission to provide your child with an assessment and with mental health services. Or, if your child is 12 years of age or older, the law may allow your child to give us his or her permission in certain circumstances.

CONSENT FOR MENTAL HEALTH TREATMENT: You agree that your child may receive a mental health assessment. If your child is under 12 years of age, you may receive a copy of that assessment. You also agree that your child may receive mental health services from a mental health professional. These mental health services may include one or more of the following: psychotherapy, individual counseling, group counseling, psychological testing, case management, individual rehabilitation, intensive day treatment, day rehabilitation, and therapeutic behavior services (TBS), and other appropriate and recognized mental health services appropriate to your child's needs. The mental health professionals that may provide services to your child include psychiatrists, psychologists, clinical social workers, registered nurses, case managers, mental health nurses, psychiatric technicians, and mental health rehabilitation specialist, community workers, volunteers, and parent partners, or other appropriate professionals. Your child may receive these services at one or more locations. The mental health professionals that provide services to your child will comply with any and all mandatory child abuse reporting laws. You may be asked to participate in your child's mental health treatment, including attending counseling sessions. This is not a consent for psychiatric medication. If you agree, and later change your mind, you can withdraw your consent for mental health treatment.

BY SIGNING THIS FORM, YOU ARE AGREEING THAT YOUR CHILD MAY BE ASSESSED AND THAT MENTAL HEALTH SERVICES MAY BE PROVIDED TO YOUR CHILD WHILE YOUR CHILD IS RECEIVING SERVICES FROM DCFS. BY SIGNING THIS FORM, YOU ARE NOT AGREEING TO PAY FOR THESE SERVICES.

SIGNATURE OR PARENT(S)/LEGAL GUARDIAN(S) DATE

☐ Parent refused to sign. Date:

AUTHORIZATION FOR DISCLOSURE OF CHILD'S PROTECTED HEALTH INFORMATION

Name of Child: Date of Birth:

Name of Parent/Legal Guardian:

At my request, I authorize any physician, health care professional, hospital, clinic, laboratory, medical facility or other health care provider that has provided treatment or services, including mental health treatment, to my child/the child named above to disclose (this includes releasing copies of) my child's entire medical or mental health record/complete patient file and relevant mental health information upon request to authorized employees of the Los Angeles County Department of Children and Family Services (DCFS).

I am the parent/legal guardian of the child/client named above and authorized to make this request. This authorization is valid while my child is receiving child welfare services, including on a voluntary basis, from the Department of Children and Family Services and shall expire once my child is no longer receiving child welfare services.

SIGNATURE OR PARENT(S)/LEGAL GUARDIAN(S) DATE

☐ Parent refused to sign. Date:

I understand that I may refuse to sign this Authorization form without affecting my child's ability to receive or obtain treatment.

I understand that information disclosed as a result of my signing this Authorization form may no longer be protected by federal health information privacy laws and may be subject to re-disclosure by recipients of this information. However, State confidentiality laws that protect health information and/or child welfare information will still apply.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Receive a Copy of this Authorization: I understand that if I agree to sign this Authorization form, which I am not required to do, I must be provided with a signed copy of the form.

Right to Revoke or Withdraw this Authorization: I understand that I have the right to withdraw this Authorization at any time by telling the Department of Children and Family Services in writing. I understand that even if I withdraw or revoke my Authorization, that will not prevent disclosures of my child's information by health care providers who have already relied on this Authorization. I may use the Revocation of Authorization at the bottom of this form. Mail or Deliver the Revocation of Authorization to:

Department of Children and Family Services,
Name of CSW:

REVOCATION OF AUTHORIZATION

I am the Parent/Legal Guardian of the Child Named Above and I revoke this Authorization.

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SIGNATURE OF PARENT/LEGAL GUARDIAN DATE